

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2014
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 assisted by only one (1) SRNA at the time, and rolled too close to the edge of the bed and ended up rolling out onto the floor. The resident stated he/she "yelled" and five (5) other staff arrived after that. Resident #8 stated he/she had hurt his/her right leg.

Phone interview, on 05/14/14 at 4:40 PM, with SRNA #4 revealed she was frequently assigned to Resident #8. She stated on 03/06/14, she was providing incontinence care for Resident #8 which included perineal care and applying a new brief. SRNA #4 stated Resident #8 rolled over too far in the bed and fell to the floor landing on her/his buttocks with her/his back against the dresser and wall. She reported she went to get the nurse who assessed Resident #8 by obtaining vital signs and checking the resident's arms and legs for movement. Continued interview revealed Resident #8 denied pain, and she and the nurse assisted the resident to a standing position and back on the bed. SRNA #4 stated she was never questioned or educated by the DON or by administrative staff related to the incident, and was still turning and repositioning Resident #8 by herself, although the resident still tried to help when being turned and often rolled over too far. SRNA #4 stated other staff were also turning and positioning Resident #8 in the bed without assistance. However, review of the Daily Care Plan Record used by SRNAs when providing resident care, revealed Resident #8's was revised on 03/06/14 for the resident to have two (2) person assistance with bed mobility. Further interview with SRNA #4 revealed SRNA's were to refer to the "nurse aide care plan" (Daily Care Plan Record) at the nurse's station when providing care for residents; however, she had nothing to reference for care needs while she was

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 issues are corrected immediately. Documentation is provided to the Administrator and the Safety Committee.

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in residents' rooms and had to try to remember all interventions for the residents. She stated she was unsure what the care plan said regarding bed mobility for Resident #8.

Phone Interview, on 05/14/14 at 5:05 PM, with Registered Nurse (RN) #2 who was assigned to Resident #8 at the time of the fall on 03/06/14, revealed SRNA #4 came to her and reported the resident had rolled out of bed and had landed on the floor but had not hit his/her head. She stated she assessed Resident #8 by obtaining vital signs, and assessed for range of motion and pain. RN #2 stated she and SRNA #4 assisted the resident back to bed and she did not remember if they used a mechanical lift for transfer or stood the resident up. She stated she had filled out an Incident Report and also written the fall incident on the Twenty-Four (24) Hour Report. RN #2 reported she thought she had documented the incident and her assessment of the resident in the Nurse's Notes. She stated she was never educated related to the incident or questioned by the DON or administration. RN #2 stated she thought Resident #8 was still to have only a one (1) person for bed mobility and did not think that had changed. However, review of the Comprehensive Care Plan and SRNAs "Daily Care Plan Record" revealed they were revised 03/06/14 for Resident #8 to have assistance of two (2) staff with bed mobility. Further interview with RN #2 revealed staff were to refer to the "Nurse Aide Care Plan" or the Comprehensive Care Plan as a reference for care needs for residents.

Continued interview on 05/14/14 at 5:15 PM and 5:45 PM, with the MDS Coordinator revealed she obtained information needed to complete the

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Monitoring for Sustainment
Results of the weekly environmental rounds are monitored by the Administrator and reviewed by the Safety Committee that meets monthly for recommendations and follow-up. The facility's DON, ADON, and/or Quality Assurance Nurse completes weekly reviews following the routine Care Conference schedule. Reviews are completed utilizing a checklist that includes falls risk assessments and attending Care Conference meetings. These reviews will occur weekly for 1 month. Reviews will resume monthly as part of the facility's Quality Assurance (QA) program. The results of these reviews are submitted for review to the QA committee members monthly.

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F 323 Continued From page 37

MDS's by interviewing staff about residents' care needs and functional abilities. She stated she also had the SRNAs' complete the seven (7) days of the ADL Tracker form which specified what type of assistance the resident required and how many staff was required to assist the resident in bed mobility, ealing, transfers and toileting. The MDS Coordinator stated she also observed staff during care to see how much assistance residents required. She stated she generated the Comprehensive Care Plans and the Daily Care Plan Record from the MDS Assessments. According to the MDS Coordinator, she completed the Daily Care Plan Record at the beginning of each month. Continued interview revealed for Resident #8 she should have noted on the Comprehensive Care Plan and the Daily Care Plan Record, the resident was to have assist of two (2) for bed mobility, after she completed the 01/29/14 MDS, which had revealed the resident needed two (2) for bed mobility. Further interview with the MDS Coordinator revealed the DON, Social Services (SS) and the Activltes Coordinator worked together as a team to develop and revise care plans in the care plan meetings.

Interview, on 05/14/14 at 4:10 PM and 7:00 PM and 05/15/14 at 3:45 PM, with the DON revealed the facility could not share Incident Reports or fall investigations as they were part of the facility's Quality Assurance. However, during the interview, she allowed the Surveyor to briefly glance at the investigation information to check for a nursing assessment and notifications to the Physician and Responsible Party after the fall. She stated Resident #8's fall occurred on 03/06/14 at 6:00 AM, and she had written the late entry related to the fall on 03/06/14 at 8:45 AM.

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F 323 Continued From page 38
 She further stated she had taken information from the Incident Report, completed by RN #2, to document the late entry including vital signs. The DON revealed the nurse, RN #2, who assessed Resident #8 should have documented her assessment in the Nurse's Notes because the Incident Report and fall investigation were not a part of the permanent record. She stated her expectation was for the nurse to assess for pain, skin condition, range of motion, vital signs, and document this assessment, as well as, document notifications to the Physician and responsible party. Continued interview revealed her investigation of the fall consisted of reading the Incident Report and fall investigation completed by RN #2 and interviewing Resident #8. According to the DON, the last MDS completed prior to the fall on 03/06/14, was a Quarterly MDS completed on 01/29/14, which stated the resident required two (2) to assist with bed mobility. She stated the Comprehensive Care Plan and the Daily Care Plan Record should have also reflected Resident #8's assessed need for two (2) to assist with bed mobility, as the Care Plan was generated from the MDS. The DON reported normally the MDS Coordinator completed the Care Plans which were reviewed for accuracy in the Care Plan meeting by her and the interdisciplinary staff, which consisted of the Social Worker, the MDS Coordinator and sometimes therapy staff. She stated this information was then placed on the Nurse Aide Care Plan/Daily Care Plan Record by the MDS Coordinator. The DON revealed the interdisciplinary team met as a group the next morning after any fall to discuss the reasons for the fall and any new interventions needed. She stated in regards to Resident #8's fall she felt the root cause of the fall was the resident being

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F 323 Continued From page 39
 assisted with one (1) staff, instead of two (2) as assessed for bed mobility. She stated both the Comprehensive Care Plan and the Daily Care Plan Record was updated on 03/06/14 for two (2) staff to assist with bed mobility. Further interview with the DON, revealed she had not performed interviews or re-education with the staff involved at the time of the resident's fall, and confirmed changes in the care plan were not necessarily verbalized to staff. The DON stated the SRNA's were to review the Daily Care Plan Record daily, at the beginning of each shift. She further stated all communication to staff for any changes made in reference to care of the resident, was by review of the Daily Care Plan Record or Comprehensive Care Plan, as there was not necessarily verbal communication to staff when a change was made.

Interview, on 05/14/14 at 6:35 PM, with the Quality Assurance Nurse revealed changes made to the Comprehensive Care Plans or the Daily Care Plan Record were not communicated verbally to staff; however, the SRNA's were expected to read the Daily Care Plan Record at the beginning of each shift and should recognize any changes then.

2. Observation on initial tour of Room 211 on 05/13/14 at 11:27 AM revealed a hanging ceiling vent cover over the toilet seat in the resident bathroom.

Interview with SRNA #1 on 05/13/14 at 11:34 AM, revealed the ceiling vent cover had been like that "for awhile". She stated the vent cover should have been reported to maintenance, especially since it could have fallen and hit a resident in the head and caused injury.

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F 323	Continued From page 40 Interview with the Quality Assurance Nurse on 05/13/14 at 11:44 AM, revealed the ceiling vent cover should not hang from the ceiling, as it held the possibility of injury to a resident if it fell on their head. She stated the loose vent cover should have been reported to maintenance for repair. Observation on 05/15/14 at 5:44 PM with the Maintenance Director, revealed the bathroom vent cover was still loose from the ceiling in Room 211. Interview, during the observation, with the Maintenance Director revealed a loose ceiling vent cover could be a safety hazard, as it could fall on a resident.	F 323	Completion Date 6/18/14	6/18/14
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure respiratory equipment was clean and stored appropriately in a manner to prevent	F 328	F 328 D 483.25(K) <u>TREATMENT/CARE FOR SPECIAL NEEDS</u> Action for Residents Affected by Deficient Practice Resident #10 and un-sampled resident A's oxygen tubing and nebulizer tubing were corrected	

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F 328	<p>Continued From page 41 the spread of infection.</p> <p>Observation on initial tour revealed oxygen tubing and/or nebulizer tubing was not stored appropriately as per facility guidelines (bagged). The oxygen tubing and/or nebulizer tubing was observed to be stored uncovered on the residents bedside tables, on the oxygen concentrators, draped over the back of a wheelchair, stored on top of a toilet, and stored on the sink.</p> <p>The findings include:</p> <p>Review of the facility "Respiratory Equipment Change and Cleaning Guidelines, revised 11/18/05, revealed Nebulizers, nasal cannulas, and respiratory tubing was to be stored in a plastic bag when not in use.</p> <p>1. Observation on initial tour on 05/13/14 at 11:30 AM, of Room 109 revealed Resident #10's nebulizer machine was on the bedside table and the nebulizer tubing was not covered or contained, but lying on the bedside table. Further observation at the same time revealed Unsampled Resident A's nebulizer machine was on the resident's bedside table and the tubing was lying on the bedside table, uncovered. There was no bag available for the nebulizer tubing for storage for either resident.</p> <p>Continued observation on initial tour on 05/13/14 at 11:35 AM, revealed a oxygen concentrator with a nasal cannula and tubing which was uncovered lying on top of the concentrator in the hall in front of the nurses station. Unsampled Resident B's name was on the concentrator and there was no bag for storage of the oxygen tubing on the concentrator.</p>	F 328	<p>upon identification by the facilities infection control RN on 5/13/14. Oxygen tubing in room 107B was corrected upon identification by the facilities infection control RN on 5/13/14. Room 100 nebulizer tubing was corrected upon identification by the facilities infection control RN on 5/13/14. Room 108A's nebulizer tubing was corrected upon identification by the facilities infection control RN on 5/13/14.</p> <p>Identification of Other Residents Affected by Deficient Practice On 5/25/14 through 5/28/14, all licensed staff was in-serviced on respiratory equipment changing and cleaning and storage. On 5/30/14, the infection control nurse completed a facility wide infection control review to ensure that all respiratory tubing and equipment were being stored in accordance to infection control guidelines.</p>	
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F 328 | Continued From page 42

Interview on 05/13/14 at 11:35 AM with the Quality Assurance Nurse revealed oxygen tubing was to be changed weekly and bags were to be available on the concentrator to store the oxygen tubing when not in use.

2. Further observation on initial tour on 05/13/14 at 11:30 AM, revealed in Room 107 B the nasal cannula oxygen tubing was lying uncovered coiled over the back of the wheel chair. Also, in the bathroom of room 100, nebulizer tubing was observed on the back of the toilet, uncovered and unlabeled, and room 108 A revealed Nebulizer tubing on the sink, uncovered and unlabeled.

Interview with Licensed Practical Nurse (LPN) #4, on 5/14/14 11:30 AM, revealed the nurse responsible for the resident was also responsible for making sure the tubing was properly bagged and labeled. LPN # 4 further stated she was unaware of the policy regarding proper care of oxygen tubing and proper bagging of Nebulizer equipment.

Interview on on 05/14/14 at 2:10 PM and 05/15/14 at 8:00 PM with the Director of Nursing (DON), revealed the facility used to store oxygen tubing in bags when not in use; however, she was unsure if this was still being done. She further stated she was unsure if the nebulizer tubing was to be bagged. Continued interview revealed she could see how it could be an infection control issue if the oxygen tubing and nebulizer tubing was not covered/contained. She stated she needed to provide an in service regarding proper care of oxygen and nebulizer equipment as per policy.

F 328

Systemic Changes for Non-Recurrence

Infection control rounds are completed by supervisory staff daily x four weeks and weekly thereafter once compliance has been sustained. Any infractions identified during rounds are reported to the facilities' infection control RN for one on one follow-up with facility staff.

Monitoring for Sustainment

Results of the daily infection control rounds are reviewed at the clinical meeting held on weekdays. The clinical meeting team members will make recommendations and provide follow-up related to respiratory equipment labeling and storage when not in use. Results of the weekly infection control rounds are reviewed at the infection control sub-committee meeting which is held monthly. The infection control sub-committee will make recommendations and provide follow-up related to respiratory equipment storage when not in use.

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F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of</p>	F 431	<p><u>F 431 D 483.60(B), (D), (E) DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS</u></p> <p>Action for Residents Affected by Deficient Practice</p> <p>No residents were identified as having been affected. Upon identification, the two (2) expired vials of Influenza Virus Vaccine were removed from the facility medication room refrigerator and placed in the sharps container for disposal.</p> <p>Identification of Other Residents Affected by Deficient Practice</p> <p>On 6/5/14 a thorough review of all medication storage areas was completed by a pharmacy representative to ensure no medications had expired, no concerns were identified by the pharmacy representative. An additional review was completed on 6/9/14 by the house supervisor with no concerns noted in this review.</p>	
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F 431	<p>Continued From page 44</p> <p>facility's policy, it was determined the facility failed to ensure appropriate storage of drugs and biologicals. Observation of the medication refrigerator revealed two (2) vials of Influenza Virus Vaccine with an expiration date of 04/20/14.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Medication Storage in the Facility Policy", undated, revealed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures should immediately be removed from stock.</p> <p>Observation of the medication refrigerator on 05/15/14 at 2:00 PM revealed two (2) vials of Influenza Virus Vaccine with an expiration date of 04/20/14 ready for use.</p> <p>Interview, on 05/15/14 at 2:00 PM, with Licensed Practical Nurse (LPN) #3 at the time of the observation revealed all the nurses assisted in removing expired items from the medication refrigerator to send back to pharmacy and also the pharmacy periodically checked the medication refrigerator for expired medications.</p> <p>Interview with the Director of Nursing (DON), on 05/15/14 at 8:00 PM, revealed she and the Assistant Director of Nursing (ADON) checked the medication room and the medication refrigerator daily on alternating days. She further stated the pharmacist consultant also checked the medication room and medication refrigerator and the influenza vials should have been removed.</p>	F 431	<p>Systemic Changes for Non-Recurrence</p> <p>Individual in-servicing has been completed with licensed nurses on medication storage effective 5/28/14 through 5/31/14. The Quality Assurance nurse audits the medication refrigerator daily.</p> <p>Monitoring for Sustainment</p> <p>The results of the medication storage audits are submitted to the Quality Assurance Committee who meets monthly for review and further recommendations as needed.</p> <p>Completion Date 6/18/14</p>	6/18/14
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E Continued From page 45
SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

F 441
F 441 E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441 Continued From page 46

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of thirteen (13) sampled residents (Resident #5).

Observation of perineal care provided for Resident #5 revealed poor infection control technique during the perineal care and/or prior to the perineal care.

Observation revealed staff did not wash their hands prior to donning gloves and placed a trash bag on the sink in a resident's room.

Also, observation on initial tour and during the survey revealed urinals and graduated cylinders were not labeled with the resident's name.

In addition, observation of the hydration pass/snack cart pass revealed staff was placing soiled dishes on the same snack cart from which snacks were being passed.

The findings include:

1. Review of the facility's "Perineal Care Performance Evaluation Checklist", undated, revealed for male perineal care staff were to: wet a washcloth; make a mitt and apply soap; wash the pubis and penis, and if uncircumcised, pull back the foreskin and wash; carefully dry and

F 441 **Action for Residents Affected by Deficient Practice**

Resident #5 was re-assessed by the Staff Development Coordinator on 5/14/14 and Resident #5 was provided appropriate perineal care by the Staff Development Coordinator. Urinals in rooms 105, 203, 106, 210, and 212 were correctly labeled by the staff development coordinator on 5/14/14. The graduated cylinder in room 206 was correctly labeled by the Staff Development Coordinator on 5/13/14. SRNA #8 was re-educated and observed on proper perineal care by the Staff Development Coordinator on 5/14/14. SRNA #10 was re-educated and observed by the Staff Development Coordinator regarding proper hand washing techniques on 5/14/14. SRNA #11 and SRNA #5 was re-educated by the Staff Development Coordinator regarding proper labeling and storage of urinals and graduated cylinders on 5/14/14. SRNA #3 was re-educated by the facility Administrator on 5/16/14 regarding proper snack pass procedures in regards to best infection control practices.

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F 441	<p>Continued From page 47</p> <p>return foreskin to normal position; make sure the shaft of the penis was dry; obtain a clean wash cloth and wash the scrotum; rinse and pat dry; turn the resident and use a new wash cloth and wash around the anus, rinse and dry.</p> <p>Review of Resident #5's medical record revealed diagnoses which included Parkinson's Disease. Review of the Annual Minimum Data Set (MDS) Assessment, dated 04/03/14, revealed the facility assessed the resident as being severely cognitively impaired and as always incontinent of bowel and bladder.</p> <p>Observation on 05/14/14 at 3:22 PM, of perineal care for Resident #5, revealed State Registered Nursing Assistant (SRNA) #8 performed the perineal care by cleansing the resident's groin area bilaterally and then cleaning between the abdominal folds. The resident was repositioned and the buttocks and anal area was cleaned next. Further observation revealed the SRNA failed to cleanse Resident #5's penis or scrotum, as per the policy, prior to applying a new brief.</p> <p>Interview with SRNA #8 on 05/14/14 at 3:30 PM, revealed she had been a SRNA at the facility for ten (10) years and had been checked off on perineal care by the Staff Development Nurse. She stated she had not cleansed the resident's penis and scrotum as sometimes Resident #5 became agitated, and she was trying to hurry before this occurred. Further interview revealed Resident #5 should have been cleaned well because the resident had experienced Urinary Tract Infections (UTIs) in the past.</p> <p>Interview on 05/14/14 at 6:25 PM, with the Staff Development Nurse revealed all SRNA's were</p>	F 441	<p>Identification of Other Residents Affected by Deficient Practice Systemic Changes for Non-Recurrence</p> <p>On 5/30/14, the infection control nurse completed a facility wide infection control review to ensure that all urinals and graduated cylinders were being stored in accordance to infection control guidelines.</p>	

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F 441	<p>Continued From page 48</p> <p>observed to ensure competency for perineal care and Foley catheter care on hire, then randomly. She stated the facility had not given any recent inservices on perineal care; however, the correct procedure was to cleanse the penis, tip to base, and then the scrotum. She stated the "Perineal Care Performance Evaluation Checklist", was a guide for providing perineal care.</p> <p>2. Review of the facility's policy titled, "General Recommendations for Handwashing", undated, revealed hands were to be decontaminated: before having direct contact with residents; after contact with a resident's intact or non-intact skin; after contact with inanimate objects in the immediate vicinity of a resident; and, after removing gloves.</p> <p>Observation on 05/14/14 at 4:55 PM, revealed SRNA #10 put gloves on without washing her hands, then took a trash bag out of the trash can and placed it on the sink. After Surveyor intervention regarding the facility's handwashing procedure, the SRNA removed her gloves, washed her hands, donned new gloves and proceeded with perineal care.</p> <p>Interview, on 05/14/14 at 4:55 PM, with SRNA #10 revealed she did not always wash her hands prior to resident care because she did not think her hands had to be washed if she was going to wear gloves for provision of care. She stated she washed her hands prior to leaving residents' rooms. Further interview revealed she had started working at the facility three (3) months ago and received Infection Control training at that time.</p> <p>Interview, on 05/14/14 at 5:24 PM, with the</p>	F 441	<p>Systemic Changes for Non-Recurrence</p> <p>All licensed staff was re-educated regarding urinal and graduated cylinder labeling and storage techniques beginning on 5/29/14 through 5/31/14. All licensed staff was in-serviced and observed to perform appropriate perineal care on 5/21/14 through 5/24/14. All facility staff was in-serviced and tested on proper hand-washing techniques on 6/3/14 through 6/5/14. All facility staff was in-serviced on infection control protocols during meals and snack time on 5/21/14 through 5/23/14. Nursing Assistants are observed every three months on hand-washing and peri-care by the Staff Development Coordinator. Infection control rounds are completed daily by infection control committee members for a minimum of four (4) weeks.</p>		

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F 441	<p>Continued From page 49</p> <p>Assistant Director of Nursing (ADON) revealed staff should wash their hands upon entering residents' rooms, and prior to donning gloves. She stated SRNA #10 should not have put the trash bag on the sink, and the trash bag should have stayed in the can until care was completed.</p> <p>Interview, on 05/14/14 at 5:37 PM, with the Director of Nursing (DON) revealed staff should always wash their hands prior to donning gloves.</p> <p>Interview, on 05/15/14 at 8:07 PM, with the Registered Nurse (RN) Staff Development Coordinator revealed staff were to wash their hands prior to putting gloves on, and staff were to wash their hands when they entered a resident's room. Further interview revealed SRNA #10 should not have put the trash bag on the sink. She stated the facility was responsible for protecting the residents from contamination and it could be a "life or death" situation.</p> <p>3. Review of the facility's, "Regulatory Focus Bulletin", revised May 2008, revealed urinals and bedpans were to be labeled with the resident's name when used or stored in an area considered multi-use, for example for residents residing in semi-private or ward rooms.</p> <p>Observation on 05/13/14 at 3:20 PM, revealed two (2) graduated cylinders on the back of a shared bathroom toilet, one (1) of which had Room 105 B marked on it. However, continued observation revealed the other cylinder was labeled with the room and bed number or a resident's name.</p> <p>Further observation on 05/14/14 at 9:30 AM, revealed a graduated cylinder in the bathroom on</p>	F 441	<p>Monitoring for Sustainment</p> <p>The results of the infection control rounds and infection control education are submitted to the Quality Assurance Committee that meets monthly for recommendations and follow-up.</p>	6/18/14

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F 441 Continued From page 50

the back of the toilet in room 206 which was a shared bathroom that was not labeled.

Interview with SRNA #11, revealed she was assigned to room 206. She stated the graduated cylinders should be labeled with a resident's name.

4. Observation during the initial tour of the facility on 05/13/14 at 11:11 AM, revealed an unlabeled urinal hanging in the shared bathroom of room 203. Continued observation on 05/14/14 at 11:15 AM, revealed unlabeled urinals in the shared bathrooms for rooms 106, 210 and 212.

Interview with SRNA #5 on 5/14/14 at 11:15 AM, revealed the SRNAs were responsible for ensuring urinals were labeled with residents' names or room and bed number. SRNA #5 stated she stored urinals on the back of the toilet after use. SRNA #5 stated an unlabeled urinal could not affect a resident's health or care.

Interview with SRNA #7 on 5/14/14 at 11:55 AM, revealed on orientation she was informed of the proper care and storage of urinals by another SRNA. She stated the urinals were to be placed on the back of the commode and staff would know what urinal belonged to which resident whether or not the urinal was labeled.

Interview with the DON on 5/14/14 at 2:10 PM, and on 05/15/14 at 8:00 PM, revealed SRNA's were responsible for ensuring all urinals were labeled with each residents' name and room number. The DON stated the graduated cylinders should be labeled with a date and the resident's name and should be bagged when used or stored. The DON further stated all staff

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F 441	Continued From page 51 members were required to follow policy and procedure related to infection control. She indicated she expected staff to follow standard precautions for every resident to reduce the potential for cross contamination. 5. Review of the facility's "Snacks" policy, undated, and the facility's "Infection Control Policy", reviewed and revised May 2008, revealed the policies did not address the collecting and handling of soiled dishware from residents' rooms. Observation on the 200 unit on 05/13/14 at 3:15 PM, revealed soiled dishes were stored on the top of the clean area of the snack cart which contained residents' prepared snacks. Interview, on 05/13/14 at 3:17 PM, with SRNA #3 revealed snacks were passed twice daily during the day shift and staff had placed the soiled dishes on top of the cart after feeding residents who required feeding assistance. She further stated placing the soiled dishes with the snacks was not an infection control issue; however, it would be helpful to have a trash container on the snack cart. Interview, on 05/14/14 at 9:25 AM, with the Dietary Manager revealed soiled dishes should not have been placed on the cart with the snacks because it would cause an issue of cross contamination. Interview, on 05/14/14 at 10:00 AM, with the DON revealed the Restorative Aide usually passed the snacks and the soiled dishes should not have been placed with the clean dishes and snacks. The DON stated the soiled dishes should have	F 441	Completion Date 6/18/14		

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F 441	Continued From page 52 been placed underneath the snacks or on an empty tray to prevent cross contamination.	F 441		6/18/14
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	F 465 E 483.70(h) <u>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</u>	
	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the environment was safe and sanitary for residents, staff and visitors, as evidenced by, toilet bolt covers missing in the bathrooms and torn wallpaper in the hallway throughout the facility.</p> <p>In addition, the residents' rooms and general bathrooms had chipped tiles on the floors, and/or missing tiles under the sinks. Also, the 100 hall had eight (8) cracked floor tiles at the fire doors.</p> <p>Further observation revealed room 209 had a brownish stain over the bed and the bathroom ceiling had peeling paint and a brownish stain.</p> <p>Additionally, the general bath on the 200 Hall had a black substance on the grout between the tiles, and the shower floor had a brown substance on the shower floor.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation during the initial tour on 05/13/14 at 12:00 PM, revealed the general bathroom on 		<p>Action for Residents Affected by Deficient Practice</p> <p>The brown substance (tile glue) on the shower floor on the 200 Hall was removed on 6/3/14. Bolt covers were installed on 6/9/14 in rooms 200, 201, 202, 203, 204, 205, 208 and 211. Bolt covers were installed on 6/9/14 in the general bathrooms for the 100 and 200 units. The tiles were replaced on 6/6/14 in the 200 hall shower room. The wallpaper in the facility was removed on 6/11/14. The tiles in rooms 206, 211, 105, and the 100 hallway was replaced on 6/13/14. The brownish stain over the bed in room 209 and the peeling paint on the bathroom ceiling was repainted on 6/4/14.</p>	

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F 465 Continued From page 53
the 200 Hall had a brown substance on the shower floor. In addition, observation revealed there was a black substance on the grout between the tiles at the base of the shower.

Interview with the Assistant Director of Nursing (ADON) at the time of the observations of the general bathrooms, revealed the substance on the floor of the 200 Hall General Bathroom looked like bowel movement. The ADON stated staff was to clean and disinfect the showers after each one, and the disinfectant was locked in the bathroom cabinet. She further stated she was unsure of what the black substance was between the tiles; however, she indicated she did not think it was mold.

Interview on 05/15/14 at 3:25 PM, with State Registered Nursing Assistant (SRNA) #9 who worked the 200 Hall, revealed after staff gave a shower, they were to spray the shower chairs and floor with "Oasis Orange Force Cleaner" (an all purpose cleaner).

Interview, on 05/15/14 at 3:00 PM, with Housekeeper #1 revealed she was responsible for cleaning the shower rooms on the 200 Hall. She stated she cleaned and checked the shower rooms two (2) times a day and used bleach water on the floors, and used a sponge mop and bleach water for the walls. She stated however, she was unable to remove the black substance between the tiles.

Interview with the Housekeeping Supervisor on 05/15/14 at 3:30 PM, revealed the housekeepers were to clean the general bathroom and showers one (1) time a day and as needed with "Disinfectant 2.0" (a broad spectrum

F 465
Identification of Other Residents Affected by Deficient Practice
All residents have the potential to be affected by the notations in F 465. The Maintenance Director and the Administrator surveyed the facility on 5/21/14 and 6/2/14 to identify any areas of concern noted in F 465.

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F 465	<p>Continued From page 54 anti-microbial cleaner).</p> <p>2. Further observation on initial tour on 05/13/14 from 11:08 AM until 12:00 PM, revealed toilets without bolt covers in rooms 201, 203, 205 and 211, and also in the general bathrooms for the 100 and 200 units.</p> <p>Observation on the environmental tour on 05/15/14 at 5:44 PM, revealed toilet bolt covers were also missing in the bathrooms of rooms 200, 202, 204 and 208. Further observation revealed two (2) one inch by one inch (1" x 1") and two (2) four inch by four inch (4" x 4") wall tiles were broken in the 200 hall shower room and wallpaper was torn in the hallways throughout the facility. In addition, observation revealed the floor in room 206 had three (3) chipped tiles, the floor in room 211 had one (1) chipped tile, the floor in room 105 had four (4) missing tiles under the sink and four (4) chipped tiles, and the 100 hallway had eight (8) cracked floor tiles at the fire doors. Also, observation revealed room 209 had a brownish stain over the bed and the bathroom ceiling had peeling paint and a brownish stain.</p> <p>Interview, on 05/15/14 at 5:44 PM, with the Maintenance Director revealed he did not look at toilet bolts to ensure they were covered as often as he should. He stated he had glued the torn wallpaper; but, it had torn again when wheelchairs rubbed it. He stated the wallpaper needed to be replaced. The Maintenance Director stated the brownish stain in room 209 appeared to be water damage which he had not noticed prior to that day. He reported he also was not aware of the peeling paint in room 209 and he did not know the floor tiles were missing under the sink in Room 105. He stated the facility had</p>	F 465	<p>Systemic Changes for Non-Recurrence</p> <p>The Maintenance Director will make weekly rounds throughout the facility with the Administrator and/or Director of Nursing to identify any concerns relating to floors, ceilings, fixtures and walls.</p> <p>Monitoring for Sustainment</p> <p>The weekly rounds conducted by the Maintenance Director and the Administrator are reviewed by the Quality Assurance Committee that meets monthly for recommendations and follow-up.</p>	
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F 465	Continued From page 55 discussed replacing the floor tile with vinyl because they could not get the same tile currently on the floor. Continued interview revealed he expected staff to notify him when they observed anything in need of repair.	F 465	Completion Date 6/18/14	6/18/14
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records for each resident in accordance with accepted professional standards and practices that were complete, accurately documented and readily accessible for one (1) of fourteen (14) sampled residents (Resident #8). Resident #8 experienced a fall on 03/06/14 at 6:00 AM; however, review of the resident's	F 514		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 56</p> <p>medical record revealed no documented evidence of the fall, to include the nurse's assessment and Physician and family notification at the time of the fall.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Fall Management Program", updated 10/16/12, revealed after a fall the charge nurse was to ensure acute charting was initiated.</p> <p>Review of Resident #8's medical record revealed diagnoses which included Dementia, a History of a Fracture to the Neck of the Femur, and Cerebrovascular Accident. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 01/29/14, revealed the facility assessed the resident as cognitively intact.</p> <p>Review of the Nurse's Notes, dated 03/06/14 at 8:45 AM revealed a "late entry" completed by the Director of Nursing (DON) for 03/06/14 at 6:00 AM. Review of the "late entry" Note revealed a State Registered Nursing Assistant (SRNA) reported assisting Resident #8 to turn in the bed, and the resident rolled out of the bed. Continued review of the "late entry" Note revealed vital signs were documented and it noted Resident #8 reported he/she rolled out of bed. Further review of the "late entry" Note revealed the Physician was notified with no new orders received and the family was notified. However, review of the Nurse's Notes revealed no documented evidence a Nurse's Note was written at the time of Resident #8's fall at 6:00 AM on 03/06/14, by the nurse who had assessed the resident at the time of the fall.</p>	F 514	<p><u>F 514 483.75(I)(1) RESIDENT RECORDS- COMPLETE/ACCURATE/ACCESSIBLE</u></p> <p>Action for Residents Affected by Deficient Practice</p> <p>Resident #8's chart reflects a summary of the events that occurred the morning of 3/6/2014. RN #2 assessed the resident immediately after the fall and completed vital signs, a pain evaluation and the facility's internal event reporting documents. RN #2 was verbally counseled on timely documentation of the nurse's notes on 3/6/2014 by the Director of Nursing. RN #2 was re-educated and received written counseling again on 6/7/2014 by the DON and SDC regarding timely and complete documentation in the resident's medical record.</p>	

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F 514 | Continued From page 57

Phone Interview on 05/14/14 at 5:05 PM, with Registered Nurse (RN) #2 who was assigned to Resident #8 at the time of the fall on 03/06/14, revealed SRNA #4 had reported the resident had rolled out of bed and onto the floor. RN #2 stated she assessed Resident #8, obtaining vital signs and assessing for range of motion and pain. RN #2 stated she had completed an Incident Report and also written the resident's fall incident on the "Twenty-Four (24) Hour Report". She stated she thought she had documented Resident #8's fall and her assessment of the resident in the Nurse's Notes. Continued interview revealed she was never questioned by the DON related to the incident or related to her lack of documentation of the incident.

Interview on 05/14/14 at 4:10 PM and 7:00 PM and 05/15/14 At 3:45 PM, with the DON, revealed the facility could not reveal Incident Reports or fall investigations because they were part of the facility's Internal Quality Assurance; however, she did allow the Surveyor to briefly look at the fall investigation information related to Resident #8's fall, to check for a nursing assessment and notifications to the Physician and Responsible Party after the fall. The DON stated she had written the "late entry" related to Resident #8's fall on 03/06/14 at 8:45 AM; however, the fall had actually occurred on 03/06/14 at 6:00 AM. She stated she had reviewed the information from the Incident Report completed by RN #2 in order to complete the "late entry" for the Nurse's Notes including vital signs. Continued interview with the DON, revealed RN #2 assessed Resident #8 and should have documented her assessment in the Nurse's Notes because the Incident Report and fall investigation were not a part of the resident's permanent medical record. The DON stated her

F 514

Identification of Other Residents Affected by Deficient Practice
DON and Nurse Consultant reviewed the past 3 months of facility internal event documentation to ensure the medical records reflect the residents' status beginning 6/9/14 through 6/14/14.

Systemic Changes for Non-Recurrence
The incident reports and nurses' notes are reviewed daily in the morning clinical meeting by the DON and IDT. The reviews are completed utilizing a checklist and will include reviewing the resident's incident report and nurses' notes. On 6/7/14 through 6/13/14 all licensed nurses' were re-educated by the DON and SDC regarding appropriate documentation as it relates to events.

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F 514 Continued From page 58
expectation was for the nurse to perform an assessment after a fall and document the assessment, as well as, notifications of the Physician and the responsible party in the Nurse's Notes. She indicated the acute charting should have been initiated by RN #2 through her assessment documentation. Further interview with the DON, revealed she had done no interviews or re-education with the RN at the time of Resident #8's fall. She stated she also had not spoken to RN #2 related to her lack of documentation of her assessment of Resident #8 in the Nurse's Note related to the fall.

F 514
Monitoring for Sustainment
In addition to the systemic changes, a weekly audit is conducted by the Quality Assurance Nurse weekly x four weeks and 10% of the resident population monthly thereafter until compliance is sustained. The audit reviews the facility's internal event reporting documents with the content of the residents' medical records to ensure the record reflects the status of each resident. Any omissions or discrepancies are investigated and corrected immediately. Results of the audit findings are submitted to the QA Committee for review and further action as indicated.

6/18/14

Completion Date
6/18/14

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1979</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One (1) story, Type V (unprotected)</p> <p>Smoke Compartment: Four (4)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, single station smoke detectors installed in resident rooms 102, 103, 106, 107, 109, 203, 204, 209, and 210</p> <p>New panel installed 2005.</p> <p>Sprinkler System: Complete sprinkler system (dry). New dry pipe valve installed 11/15/11</p> <p>Generator: Type 2 generator powered by natural gas</p> <p>A Standard Life Safety Code Survey was conducted on 05/13/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was fifty-two (52). The facility is licensed for fifty-four (54) beds.</p> <p>The following demonstrate noncompliance with</p>	K 000	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	6/18/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 6-9-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest Scope and Severity of an "F" level.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors were maintained according to NFPA standards. This deficient practices affected four (4) of four (4) smoke compartments, staff, and approximately fifty-two (52) residents. The facility has the capacity for fifty-four (54) beds with a census of fifty-two (52) on the day of the survey. The findings include: During the Life Safety Code survey on 05/13/14 at 12:50 AM, with the Director of Maintenance, exit doors located at 100 Hall, revealed the signage for delayed egress did not have a contrasting background. This observation was also made on the 200 Hall at 1:03 PM, the dining room at 1:10 PM, and at the front entrance door at 1:14 PM.	K 038	<u>K038 F Exit Access are Readily Accessible at All Times</u> Action for Residents Affected by Deficient Practice No specific resident was identified to be affected by the deficient practice. See actions below for all residents.	6/18/14

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K 038 Continued From page 2

Interview with the Director of Maintenance on 05/13/14 at 1:35 PM, revealed he was not aware of this requirement.

Interview with the Administrator on 05/13/14 at 1:55 PM, revealed she was not aware of the requirement; however, would get the signage replaced as soon as possible.

Additional observation during the survey on 05/13/14 at 1:09 PM, with the Director of Maintenance, revealed the gate in the courtyard did not swing in the direction of egress.

Interview with the Maintenance Director on 05/13/14 at 1:09 PM, revealed he was not aware of the gate swinging in the wrong direction.

Interview with the Administrator on 05/13/14 at 1:55 PM, revealed she was unaware of the gate swinging in the wrong direction and would get it corrected.

Reference: NFPA 101 (2000 Edition).

7.2.1.5.4*
A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.
Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.

7.2.1.6.1 Delayed-Egress Locks.

K 038

Identification of Other Residents Affected by Deficient Practice

All residents have the potential to be affected. On 5/13/2014, the gate in the courtyard was corrected to swing in the direction of egress. On 6/9/14 a contrasting background was added to the signage that reads, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". These letters are a minimum of 1" high.

Systemic Changes for Non-Recurrence

Accessible exits were added to the monthly facility-wide rounds that the maintenance technician completes to monitor exit doors. Any identified issues are corrected immediately. Documentation is provided to the Safety Committee.

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K 038	<p>Continued From page 3</p> <p>Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>19.3.6.3.2*</p>	K 038	<p>Monitoring for Sustainment</p> <p>The Administrator will review the monthly facility-wide rounds submitted to the Safety Committee once each month during the Safety Committee Meeting.</p>	6/18/14

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K 038	Continued From page 4 Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.	K 038	Completion Date 6/18/14	
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice had the potential to affect one (1) of four (4) smoke compartments, twenty-three (23) residents, staff and visitors. The facility has the capacity for fifty-four (54) beds and at the time of the survey, the census was fifty-two (52).</p> <p>The findings include:</p>	K 056	<p><u>K 056 D Automatic Sprinkler System</u></p> <p>Action for Residents Affected by Deficient Practice</p> <p>No specific resident was identified to be affected by the deficient practice. See actions below for all residents.</p> <p>Identification of Other Residents Affected by Deficient Practice</p> <p>All residents have the potential to be affected. On 5/15/14, the maintenance technician, along with the facilities contracted fire safety vendor inspected the facility to ensure that there were no areas that extended above tray ceiling areas that were not sprinkler protected. No violations were noted.</p>	

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K 056	Continued From page 5 Observation on 05/13/14 at 1:30 PM with the Maintenance Director, revealed the dining room area had two (2) twelve (12) foot by twelve (12) foot areas which extended above the tray ceiling areas that were not sprinkler protected. Interview, on 05/13/14 at 1:30 PM, with the Maintenance Director revealed he was unaware the dining room was not properly sprinkler protected. Interview, on 05/13/14 at 1:55 PM, with the Administrator revealed she did not know that the dining room was not properly sprinklered protected. According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems. Actual NFPA Standard: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The	K 056	Systemic Changes for Non-Recurrence The facility has contracted with a qualified sprinkler contractor for the installation of the needed sprinkler heads in the identified area: the two (2) twelve (12) foot by twelve (12) foot areas which extended above the tray ceiling areas in the facility dining room. Monitoring for Sustainment The newly installed sprinkler heads are inspected by the facilities contracted fire safety vendor at least quarterly to ensure adequate operation and compliance with the national fire protection association standards. These inspections are reviewed by the Administrator.		

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K 056	Continued From page 6 requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 056	Completion Date 6/18/14	
K 130 SS=D	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments. The facility has fifty-four (54) certified beds and the census was fifty-two (52) on the day of the survey. The findings include: Observation on 05/13/14 at 1:00 PM, with the Maintenance Director revealed a free standing hair dryer and two (2) curling irons plugged into a power strip located in the beauty shop beside the nurse's station. Interview, on 05/13/14 at 1:00 PM, with the Maintenance Director revealed he was aware of	K 130	<u>K 130 D POWER STRIP USAGE</u> Action for Residents Affected by Deficient Practice No specific resident was identified to be affected by the deficient practice. See actions below for all residents. Identification of Other Residents Affected by Deficient Practice All residents have the potential to be affected. On 5/27/14, the maintenance technician completed rounds throughout the facility to ensure that no additional power strips were being utilized. No violations were noted. Systemic Changes for Non-Recurrence The facilities contracted beautician was educated by the maintenance director on 5/20/14 regarding power strip usage with high-current draw devices. All facility staff was in-serviced on	

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K 130 Continued From page 7
power strips being prohibited; but, was not aware of the power strip in the beauty shop.

Interview, on 05/13/14 at 1:55 PM, with the Administrator revealed she was not aware of the power strip in the beauty shop and would educate the beautician about the power strip.

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D
Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

K 211 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:
o The corridor is at least 6 feet wide
o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
o The dispensers have a minimum spacing of 4 ft from each other
o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.
o Dispensers are not installed over or adjacent to an ignition source.
o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623

K 130 regarding power strip usage. Power strip identification rounds are completed by the maintenance director monthly. Any identified issues are corrected immediately. Documentation is provided to the Safety Committee. The Safety Committee will make recommendations and provide follow-up for proper use of power strips in the facility.

Monitoring for Sustainment
Results of the monthly power strip inspections and the Safety Committee recommendations are reviewed by the Administrator each month.

Completion Date
6/18/14

K 211 D Alcohol Based Hand Rub

Action for Residents Affected by Deficient Practice
No specific resident was identified to be affected by the deficient practice. See actions below for all residents.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2014
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Alcohol Based Hand Rub dispensers were not installed adjacent to an ignition source in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty-five (25) residents, staff, and visitors. The facility was certified for fifty-four (54) beds with a census of fifty-two (52) on the day of the survey. The facility failed to ensure two (2) alcohol dispensers were not installed adjacent to a light switch.</p> <p>The findings include:</p> <p>Observation on 05/13/14 at 1:11 PM with the Maintenance Supervisor, revealed an Alcohol Based Hand Rub Dispenser installed by the light switch in the dining room next to the exit door. Additionally, observation at 1:45 PM revealed an Alcohol Based Hand Rub Dispenser next to the front exit door.</p> <p>Interview, on 05/13/14 at 1:45 PM, with the Maintenance Supervisor revealed he was unaware they were mounted too close to the light switches in the rooms.</p> <p>Interview, on 05/13/14 at 1:55 PM, with the Administrator revealed she was unaware of this requirement and would correct the problem.</p>	K 211	<p>Identification of Other Residents Affected by Deficient Practice</p> <p>All residents have the potential to be affected. On 5/14/14, the maintenance technician removed the identified hand sanitizers noted in K 211. On 5/14/14, the maintenance director completed rounds throughout the facility to ensure that no additional hand sanitizers were installed as noted in K 211. No other hand sanitizers were found to be in conflict with K 211.</p> <p>Systemic Changes for Non-Recurrence</p> <p>Hand sanitizer inspections were added to environmental rounds that are completed by the maintenance technician weekly. Any identified issues are corrected immediately. Documentation is provided to the Safety Committee for recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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K 211	<p>Continued From page 9</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 	K 211	<p>Monitoring for Sustainment</p> <p>Results of the weekly environmental rounds and the Safety Committee recommendations are reviewed by the Administrator each month.</p> <p>Completion Date 6/18/14</p>	
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